PRIOR AUTHORIZATION REQUEST

Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists

Prescribing Physician:	Patient:	
Name (First, Last)	Name (First, Last)	
Direct Phone #	ID #	Sex (at birth): ❑ M ❑ F
Fax #	Phone #	Client
Physician specialty	Birth Date: ___/___/_____	Age

Name and title of person completing form (please print):	
1. Please select ONE of the following ❑ Aimovig (erenumab) 70mg SQ Monthly ❑ Aimovig (erenumab) 140mg SQ Monthly ❑ Nurtec (rimegepant) 75mg PO Every other day ❑ Nurtec (rimegepant) 75mg PO PRN ❑ Other: ______________________________ Drug name, dose, route, frequency	2. Patient's diagnosis use of this medication: ❑ Migraine Prevention ❑ Acute migraine treatment ❑ Other ____________________

3. Has patient been on this drug? ❑Yes ❑No If yes, for how long: ______________________

4. Has the patient trialed Botox (botulinum toxin) for at least 2 cycles? ❑Yes ❑No
If yes, indicate dates: ____________________

5. Has the patient tried/failed at least TWO of the following therapies below for ≥ 8 weeks? ❑Yes ❑No

	Reason for failure	Dates
Antiepileptics ❑ Topiramate ❑ Divalproex/valproate sodium		From ___/___/___ To ___/___/___
Beta-blockers ❑ Atenolol ❑ Metoprolol ❑ Propranolol ❑ Nadolol		From ___/___/___ To ___/___/___
Antidepressants ❑ Amitriptyline ❑ Nortriptyline		From ___/___/___ To ___/___/___
❑ Candesartan		From ___/___/___ To ___/___/___
Other therapies		From ___/___/___ To ___/___/___ From ___/___/___ To ___/___/___ From ___/___/___ To ___/___/___

6. Indicate the number of headache days per month: __________

7. Of the headache days per month, how many are migraine days for the last 3 months: __________

8. Indicated one of the following:
❑ HIT-6 (Headache Impact test): __________ ❑ MIDAS (Migraine Disability Assessment): ________

Physician's Name (print): ____________________________ **Title:** ______________

Physician's Signature: ______________________________**Date:** ___/___/_____

Fax PA request form AND Supporting Documentation to: SGRX @ 313-264-0985